



Audiology Patient Assistance (APA) Program Application

The Audiology Patient Assistance (APA) program is administered by the Department of Audiology at Cleveland Hearing & Speech Center. This program provides hearing aids, assistive listening devices and/or hearing aid repairs to low-income, qualified individuals in the Northeast Ohio area. Eligibility for the program is based on the completion of an application and proof of income, submitted by the patient. Please be advised that we can not process your application without proof of financial status. Please allow 4 weeks to process your application. A waiting period, of undetermined length, may be required before you can obtain your hearing aid and/or assistive listening device.

Hearing Aid Program

While there is no charge for the hearing aid itself, there will be charges for professional services rendered including testing as necessary. Repairs after the warranty period will be the financial responsibility of the patient. After the initial fitting, there may be additional charges to the patient for any services provided by the audiologist. Depending on our funding, we may be able to provide 1 or 2 hearing aids per patient.

All fees are DUE IN TOTAL at the time of the hearing test/ear impression visit and are NON-REFUNDABLE. We provide services on a sliding scale. If accepted into the program, typical charges range from \$54 to \$922. Remember, charges are for services only, the hearing aid itself is given at NO CHARGE. Approval into the Audiology Patient Assistance program will be canceled if another funding source is used for payment. In addition, if an insurance benefit for hearing aids becomes available, acceptance into the program will no longer be valid.

Hearing Aid Repair Program

We can assist with hearing aid repair charges. All fees are DUE IN TOTAL before we can send the hearing aid to the manufacturer for repair.

Assistive Listening Device Program

While there will be no charge for the device(s) themselves, there will be charges for professional services rendered (including audiologic testing as necessary). Devices may or may not come with a manufacturer's warranty. Warranty information will be explained at the dispensing visit. CHSC does not handle repairs of assistive listening devices. The patient is responsible for sending any malfunctioning product back to the manufacturer. CHSC does not do installations of any assistive listening device. It is the patient's responsibility to arrange for installation of the product. Installation costs are not covered by any of the fees paid to CHSC.

All fees are DUE IN TOTAL at the first visit and are non-refundable. Most devices are special ordered and will require returning to CHSC for a second visit. We provide services on a sliding fee scale. If accepted into the program, typical charges range from \$14 to \$140. Remember, charges are for services only, the assistive listening device(s) are given at NO CHARGE.

Questions regarding the Audiology Patient Assistance Program should be directed to the Department of Audiology at 440-838-1477.

Return application and proof of income to:

Cleveland Hearing & Speech Center
7000 Town Centre Dr. Suite 200
Broadview Heights, OH 44147



CLEVELAND
Hearing & Speech
CENTERSM

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Date received _____ Date reviewed _____

I hereby request that Cleveland Hearing & Speech Center make a written determination of my eligibility for the APA program. I understand that the information I submit concerning my income and family size is subject to verification by CHSC. I also understand that if the information is found to be false, such a determination will result in a denial of products and services, and that I will be liable for the full fee of services provided.

What are you applying for (check all that apply):

- ☐ Hearing aid
- ☐ Hearing aid repair
- ☐ Assistive listening device (such as amplified phone, TTY, alerting devices, etc.)

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ BIRTH DATE _____ PHYSICIAN _____

MEDICAL INSURANCE _____ (please provide a copy of your current insurance card)

Ethnicity: ☐ White ☐ Black ☐ Asian ☐ Hispanic/Latino ☐ Native American ☐ Biracial ☐ Other
(for reporting purposes only, our grant funders request certain demographic information about our applicants)

FAMILY SIZE: Please list all people currently living in your home.

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCOME: Please list monthly income for all people listed above.

Wages (including self employment) _____

Social Security _____

Pensions _____

Public Assistance _____

Other Sources of Income (including unemployment, _____

worker's compensation, alimony, child support, income from interest or dividends)

GRAND TOTAL _____

Current balance of Savings/Checking Accounts _____

You must submit documentation of the above stated income. Accepted documentation include:

1. Wage statement (e.g. social security, unemployment, public assistance, pension, etc.)
2. Bank statement
3. Social Security statement

Amounts listed above should match the documentation provided. If the amounts do not match, you may be asked to provide additional documentation.

We cannot process your application without this information!